PROJECT HOPE

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Interview with C. Everett Koop, M.D.

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PRO-TYPISTS, INC.
Professional Transcription Service
1012-14th Street, N.W., Suite 307
Washington, D.C. 20005
202-347-5395
protypists@prodigy.net

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P R O C E E D I N G S

INTERVIEWER: The date is the 24th of May, 2004. We're in the office of Dr. C. Everett Koop, at Dartmouth, in Hanover, New Hampshire. Let me just take a sound level here. Would you tell me your name, and spell it?

DR. KOOP: I am C. Everett Koop, C, period, E-v-e-r-e-t-t, capital K-o-o-p.

INTERVIEWER: All right. Good. What I'd like to do is start by talking about children's health, as I mentioned, since this is primarily a child health issue of Health Affairs that we're going into. And maybe talk most specifically first about pediatric surgery which, of course, is where you got your start in medicine. Just a word about how you've seen the development of that as a discipline, and how you feel about it looking back on it.

DR. KOOP: Well, I've always been delighted to have been associated with pediatric surgery. It was really a passion of mine, and I wish I could say that I had thought years ago that there ought to be such a

thing as pediatric surgery, but that's not the case. But I did know that children did not get a fair shake in surgery, and when I had the opportunity to be part of a new developing specialty, I seized it.

One of the things that I think made that experience so remarkable is that it was a new specialty. I was associated with the founding of the two societies that represent pediatric surgery. One was the Surgical Section of the Academy of Pediatrics, and the other was the American Pediatric Surgical Association. In addition to that, I had founded, with Stephen Gaines, the Journal of Pediatric Surgery, and had the great privilege of being the surgeon chief of the Children's Hospital of Philadelphia from 1946 until I went to be Mr. Reagan's surgeon general in 1981. So I entered on the ground floor, and what I like to say is true, and that is pediatric surgery really replicated the growth of general surgery in America, but whereas it took general surgery about 200 years to evolve, pediatric surgery started from scratch and achieved about as much as a specialty in 35 years.

INTERVIEWER: Where does it sit today? Are

you pleased with its developments, even after your active role in it?

DR. KOOP: I am pleased with part of it, and very frightened about another part. The part that I'm pleased with is that we have developed a group of young surgeons who are not just clinical surgeons and people who understand how to do good surgical procedures, but their bench research is contributing to other fields of surgery, as well, and I think that's one of the ways that a new specialty not only grows but retains the respect of its competitive --

INTERVIEWER: Their "venture search"?

DR. KOOP: Their what?

INTERVIEWER: Their -- oh, their "bench research."

DR. KOOP: Bench research.

INTERVIEWER: Bench research.

DR. KOOP: Yes, I'm sorry. The thing that worries me about the future of pediatric surgery, I give you the bottom line first. I don't think that the surgical care of my great-grandchildren will be as good as the surgical care was of my grandchildren. And let

me explain that to you.

I remember a day when I was the only pediatric surgeon south of Boston and east of the Mississippi. When we started, we were a very small group. I was the fifth person in America who called himself a child surgeon; "pediatric surgeon" wasn't invented until somewhat later. But I was the first person in America who did children's surgery exclusively. And that was as recently as 1946, so you can see we are relatively young.

The specialty grew in numbers. There was not, in the beginning, an international society of pediatric surgery, but the British Association of Pediatric Surgeons served in that capacity, and it was sort of the mother organization of other national pediatric surgical societies.

What happened to pediatric surgery is part of what happened to medicine itself. It slowly evolved from being a pure profession to being a professional business, and in business money is the bottom line, and that means that hospitals, medical centers, and even medical schools are competing against each other for

supremacy, and it got to the point, about 20 years ago, when if a small hospital didn't have a pediatric surgeon, parents knew enough about pediatric surgery that they wanted their child to be seen by someone who'd had experience with their child's problem. A reasonable and sensible request. That meant that small hospitals with no pediatric surgeon had to send from their institution, elsewhere, patients who were considered high risk pediatric surgical patients.

The resulting change in the business of pediatric surgery was that more and more hospitals advertised for a pediatric surgeon, the enticements were great, "We'll build you an ICU, we'll do this and do that for you," and the best way I can describe it is that when you have the number of pediatric surgeons multiplying the way they were, the gravy gets so thin it's not nutritious. And I am convinced, especially in a specialty like pediatric surgery where the technical prowess of the surgeon is very important to the initial success of the patient's outcome, I'm convinced that nothing succeeds like experience on experience. And today, there are so many pediatric surgeons that some of

them see very few of what we call "index cases," such esophageal atresia, diaphragmatic hernia, intestinal obstruction of the newborn, things of that particular nature, which were real technical challenges as well as physiologic challenges post-operatively, and there were times in the Children's Hospital of Philadelphia when we would have a dozen patients with esophageal atresia that came through in a single month. And in the last 20 years, when I have occasionally made rounds in other children's hospitals, the first question that I ask is, "How many esophageal atresias did you see last year?" And I get the astonishing answer, "Was that the year we had two, or was that the year we had three?"

INTERVIEWER: How many pediatric surgeons are there in the United States today?

DR. KOOP: I don't think I can answer that question for you.

INTERVIEWER: But the numbers have proliferated.

DR. KOOP: The numbers are great. Somebody told me that there are something like 800 certified pediatric surgeons, not all practicing in the United

States. That includes Canada, some from South America, but that are certified by the American Board of Surgery as pediatric surgeons.

And with the esophageal statistics, for example, my group and I did 272 esophageal atresias -- that's not right. We did 472 esophageal atresias between 1946 and 1981. And the results speak for themselves. In my own personal practice, for the last eight years that I was a surgeon, we didn't lose a patient with esophageal atresia. And our survival rate for premature babies was 88 percent. And I don't think that you can achieve that for the tough anatomical and physiologic challenges unless you have the experience that warrants your ability to meet the unexpected and to take care of it.

INTERVIEWER: Both as a pediatric surgeon and then in your role as Surgeon General, you had an extraordinary opportunity to observe the health of children or developments in the health care and health of children. How have you seen that over the last half century, and where do you feel we're headed?

DR. KOOP: Well, children occupy a very

special place in medicine. We always talk about the children being our future, and therefore they deserve our best, but I'm afraid we don't always deliver that way, and I have to admit that the older I get, the more I understand the relationship of poverty in a child and poor outcomes in everything else. And I think that I'm not beating a socialist kind of drum here, but I think, as we look to the future, unless we take into account what a severe role poverty plays in the future of children, we will never be able to attack its base causes.

Now, we have accomplished a good many things. One of the things I'm proudest of is that during my tenure as Surgeon General, working with Finch Hutchins and Norma Cursett (phonetics) of the Bureau of Maternal and Child Health, we were able to actually amend the Social Security Act, Title V thereof, so that it became the right of every special needs child in this country to have coordinated, comprehensive, family-centered, community-based care. And that was a tremendous advance, because it said the child will have the support of the family, which is so essential to developing kids

emotionally, but it also said you won't have to travel across the country to get it.

INTERVIEWER: What does that mean in terms of clinical or social support? What did that mean? What did kids get as a benefit of that they weren't before?

DR. KOOP: What they get is the ability to -- let me explain it with somebody like Katie Beckett, that is known to many people. Katie Beckett was a child who was respirator-dependent and lived in Iowa, but she was hospitalized as a Medicaid patient 30 miles from her family, and that was a great burden for the family to provide the emotional support that they needed. And Mrs. Beckett wondered why, when we had gotten children out of hospitals into their home, on a respirator, at ever so much cheaper rates per week than the hospital could do it, why that wasn't possible.

And out of that came the Katie Beckett Waivers, and that meant that Katie Beckett was transferred from a hospital to her home. That meant that it was community-based and not at a distant place. She had the emotional support of her family, so it became family-centered. It was comprehensive in that

all of the necessary specialists and those who provided social support were part of the team, and --

INTERVIEWER: And Medicaid continued to cover it.

DR. KOOP: Medicaid continued to cover it, but it was ever so much cheaper for them to do it at home. And it's interesting that just the day before we're speaking now, I noticed in the newspaper, warning that there would be tampering with the Katie Beckett Waiver System. So after all these years, we may have to fight that battle again.

INTERVIEWER: It's K-a-t-i-e?

DR. KOOP: Yeah.

INTERVIEWER: B-e-c-k-e-t-t?

DR. KOOP: Right.

INTERVIEWER: There is social criticism or political or policy criticism from time to time about the income transfer between youth and the elderly, with Medicare in particular commanding such a huge portion of our public budget, and relatively less going to children. Is that a concern you subscribe to in terms of public policy?

DR. KOOP: It's a concern that I have, because all the time that I was a pediatric surgeon, I was aware of the fact that our chief competitor was really not in the pediatric field at all, it was geriatrics. And just as --

INTERVIEWER: "Chief competitor" in the sense of?

DR. KOOP: Demand for services and the fact that people were living longer, living better, and you can't do either of those things without spending more money. And so I would say that it can be summarized by saying pediatric social and medical interests were vying with geriatric social and medical interests for an ever-increasing slice of a shrinking pie. And that doesn't make for good social service, it doesn't make for good family support, and it doesn't make for good medical outcomes.

But I would say that on balance, except for a few major things that stick out like sore thumbs, children do get a better shake. They certainly do, surgically. One of the changes --

INTERVIEWER: Than they did previously?

DR. KOOP: Than the did previously. I think one of the changes that should be noted is pediatric surgery started in a strange way, and the people who called themselves pediatric surgeons in the early days were really surgeons of the skin and all of its contents. I mean, I used to do subdural hematomas, and I'd work in the neck. I avoided the eye and the ear, but the rest of it was my domain. And it didn't mean that I kept out of the chest or the belly or the pelvis or the extremities, and for a surgeon who loves surgery the way I did, that was a wonderful system.

But if one looked at the development of general surgery in America after World War II, the great spurt in surgery, what I call "the golden era of surgery" in America, came about because of specialization. The war made specialization easy, and made it almost necessary.

INTERVIEWER: "Easy" in the sense?

DR. KOOP: Well, if you were in military situation and you suddenly had a huge bunch of burns, you've got to develop a kind of specialist that can take care of big burns. And the same is true with trauma,

and then people began to say, "Well, look, I've had so much experience in the chest, why do you abdominal surgeons keep stepping in my territory," and on it goes.

The long and short of that is that with the burgeoning of surgical specialties, I don't think there's any doubt about the fact that patients got better care and their outcomes were better. Largely on the basis of the fact that I mentioned before about pediatric surgery, study after study shows that the best outcomes are in the places that have the most experience. And surgeons did not like to see the log of general surgery cut into any more splinters, and one of the reasons that pediatric surgery faltered a little bit in getting it started in American surgical circles was that it was seen as not only the competition of another specialty, but here were a group of people who came along and said, "We can do what you do better at a certain age," and that made the competition even more telling. It wasn't just technical skills, it was understanding the physiology of a newborn and a small child.

INTERVIEWER: What do you think of the

prospects for child health as you look at the situation now, and look to the future? Is the aging of the population going to continue to create competition that kids won't be able to keep up with?

DR. KOOP: I think it depends, in the long run, _____ about advocacy. There are people who have always been child advocates, and they've done a tremendous job to advance the understanding of the public to garner public and private funds, and to, in general, move pediatrics along. But children are not able to have their own lobby, and I think there's no doubt about the fact that the geriatric lobby -- and that's not a specific group of people, it's just a tremendous variety of people who have interest in the aging population because that's where their business interests lie --

INTERVIEWER: And the aging population is not quiet group themselves.

DR. KOOP: No, they're not quite, and they vote. And I think that one of the major reasons why groups of people like handicapped children have never made the same kind of progress that elderly population

has in gaining services that they need, is that they don't have the ability to fight for themselves. And when you're fighting for yourself, I think you're fighting a different battle than when you're fighting for a class of people, like children, that you have sort of a nebulous connection to.

The one thing that I think stands out as -- I said like a sore thumb a minute ago -- and that is that the pediatric world did not recognize the fact that obesity, which is becoming a national problem, was also affecting children. And they didn't seem to understand that fat bouncing babies became fat children, and fat children became fat adolescents, and fat adolescents became fat adults. And we now have a problem that is going to be very difficult to reverse, and it has very serious implications about diseases in the long run and in later years that are associated with obesity, like Type 2 diabetes, breast cancer, colorectal cancer; that sort of thing.

INTERVIEWER: So this, in terms of the vigilance within the child health community, that's an area that perhaps might have been attended to better?

DR. KOOP: I think it could have been attended to better if, for example, I'd had another four years as Surgeon General, even though people weren't talking much about obesity in 1989, I would have made that one of the pillars of a next term.

The government were very slow, I think, to recognize what was happening with obesity and overweight, and you may recall that in the private sector I founded, with the aid of Hillary Clinton and the White House, a thing called "Shape Up America." Which was designed for the private sector working with private entrepreneurs to provide a way for people to become educated and aware of the dangers of obesity.

INTERVIEWER: Let's switch to your years as Surgeon General. As you look back on those eight years, what sort of reflections do you have about the job, about the experience, and about the outcome?

DR. KOOP: Well, no one ever tells you what the job description is of Surgeon General. And I think it's entirely possible, the way that job was organized when I arrived in Washington, to almost make it what you will. And I found that at the end of Mr. Reagan's first

term, as his early appointees began to leave government and go back to the private sector, that there were many vacuums in the government, a lot of them in public health and HHS. And waiting for somebody else to fill those vacuums, I stepped in and tried to do those jobs. I think it was appreciated by people who were leaderless, but it provided the opportunity to get several major things done.

One is, I don't think there ever has been -- had never before that been the same type of assault, not just on the problems of smoking and the health consequences thereof, but on the nefarious activities of tobacco industry and their deceitful processes, which were designed to obfuscate the public's understanding of what the government was trying to teach them. And fortunately(?), the momentum of that work has never really subsided. And I think we -- I have a terrible prospect of global expansion of smoking by the tobacco industry with the University of Cambridge statisticians predicting that by 2025 there will be an additional 500 million deaths of people now alive on this planet, due to smoking causes alone.

But the other thing that was a huge problem during my tenure was AIDS. And as I have made it abundantly clear in my writings about the subject, no one ever asked me to be the spokesperson of the government for AIDS, but it's a job that I assumed because nobody else was doing it and because, frankly, the people who advised Mr. Reagan were doing such a poor job of it. And I think the people -- and when I say "the people," I mean the public -- appreciated honest answers about a difficult disease to understand, and I think that both AIDS and smoking are the two huge problems that our global society faces in reference to health in the future. The problems have expanded, and they will not go away.

Smoking is a lot different than AIDS. Smoking involves an addictive substance, and that changes the whole aspect of the growth and development of an industry that has to replace those it kills, with new recruits on a constant basis, and the various settlements that the tobacco company has fallen heir to make it necessary for them to find new and outrageous sources of income. And they can pay the huge bill that

they established with this attorneys-general of the several states only because they had plans afoot even then to smother the rest of the world where men smoke but women didn't, and to turn their financial returns in such a way that they could pay what they had indebted themselves to do.

INTERVIEWER: Yet to these -- I do want to pursue the tobacco theme, but staying on the PHS for a moment and staying on AIDS, you described to me previously the vacuum that existed and how back of the hand or how informal your invitation to step up to the AIDS issue and develop the first AIDS report had been. Run that by me again, I mean how that happened, because I think that's an important part of history.

DR. KOOP: Well, for reasons that were never made clear to me, when AIDS was established as a disease and we knew we had an epidemic on our hands, I was told that AIDS did not come under my purview and that that would be handled by other people in the department, and I was reminded of that any time I made a public appearance or went on television or gave a lecture, that I was not to get into the subject of AIDS.

And yet, when that day came that I just mentioned a moment ago, when the original Reagan appointees began to go home to their points of origin, there were fewer and fewer people who really knew what was going on with AIDS, and it was easy to step in and by that time I had secured, I think, a sufficient confidence in the people of America that they could expect me to handle the situation with integrity, that the efforts that had been made to silence me before sort of disappeared. And I did become the spokesperson, and one of the things that aided and abetted that was that we changed secretaries of HHS, from Margaret Heckler to Otis Bowen.

Otis Bowen was a remarkable gentleman and a physician, a man with tremendous political experience, had been the governor several times of Indiana, and we struck it off as medical and political colleagues right from the start. And he made it very clear to me that it was not his intent at any time to step on my toes or get in my way, because he was very pleased with what I was doing, and he gave me every support that I could have.

The next thing that came along that was

fortuitous was that President Reagan asked me to write a report for the American people on acquired immuno-deficiency syndrome. And I don't think I've worked harder in my life on anything, and we published that, and except for treatment modalities, everything about the epidemiology of that disease and so on that was stated then is still true.

INTERVIEWER: And that report you got through with very little clearance, as I recall you and perhaps Secretary Bowen?

DR. KOOP: Secretary Bowen and I were the only people in HHS, except for two people appointed by me to be my associates, that knew what was going on. And I had agreed with Otis Bowen that if we passed this through the usual channels, of one being the Secretariat of the HHS, it would never have seen the light of day, because there were too many people, especially those surrounding the president at that time, who felt that who had AIDS after all, weren't they prostitutes, homosexuals and drug abusers and, after all, didn't they deserve what they had?

And the thing that I published had as its

theme, along those lines, we were fighting a disease, and not the people who had it. And I think that was a turning point --

(End of Tape 1, Side A)

INTERVIEWER: This is Dr. Koop, Side 2.

DR. KOOP: I do think that -- I forgot what I was saying.

INTERVIEWER: I'm sorry. The question was the clearance process and who -- and your position --

DR. KOOP: Yes. I did think that the major mistake that was made by government and the public was to treat AIDS as a political disease and not as a public health disease. I think we would not be in the terrible global situation we are right now if we had treated this the way we would have treated typhoid fever. Or syphilis. Or gonorrhea. And instead, we had special rules about privacy and special thoughts about protecting people, and as a result now we have a pandemic that is out of control in Asia and in Africa, and so --

INTERVIEWER: So you think if we'd been more incisive and more traditional in our infectious disease

approach, the epidemic would have been better contained?

DR. KOOP: I think the epidemic would have been far better contained if we had treated it according to public health principles as an infectious disease that was containable. I mean, the thing that stands out about AIDS more than anything else is its preventability. And as long as you had no way of knowing who contacts were and no way of understanding the reasons for testing and not testing, we just were in a quagmire for years.

INTERVIEWER: A word on being the Surgeon General. The metaphor, the cliché is, "bully pulpit." And you certainly used it as a bully pulpit. But beyond that, how did you feel about your prosecution of the job and what would you say about it as a position in general?

DR. KOOP: Well, I have tried to intimate that it is a job that you can make into really what you'd like to make it.

INTERVIEWER: Or, I presume, not? Should you not have the vision --

DR. KOOP: If you decided to sit and read the

New York Times, that would be also acceptable. Nobody would say, "Hey, do your job a little better."

I think the present situation, which I don't know whether you want to get into or not, but --

INTERVIEWER: Sure.

DR. KOOP: But we have a Surgeon General now whose qualifications seem to be perfectly satisfactory for the job at hand, but you don't hear much about him because he doesn't have the freedom that I was afforded by the Department of HHS; in this case, being strongly overshadowed by the White House. And so I describe Dr. Carmona as being a capable Surgeon General who is unfortunately wearing a straitjacket.

And I think that in this era where most people are a little concerned and some people greatly concerned about our preparedness for a possible biochemical terrorist attack, that this is a magnificent time for a Surgeon General with a bully pulpit to educate the people of the country, and, by moral suasion, to improve the preparedness of the public health service to deal with the problem.

INTERVIEWER: But that isn't being afforded